Approved 1-27-87 ok
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 a.m./p.m. on January 15, 1987 in room 423-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Research
Bill Wolff, Research
Sue Hill, Secretary to Committee

Conferees appearing before the committee:

Chairman called meeting to order when quorum was present.

Chair introduced Ms. Emalene Correll and invited her to brief committee this date on the Interim Proposals of the Special Committee that met this summer.

Ms. Correll gave very detailed comments about this report, and gave hand-out to each committee member on Proposal No. 24, 25, and 27. (These are shown as attachments, No. 1, No. 2, and No.3 respectively).

Ms. Correll noted recommendations from the Interim Committee as, i.e., attention be given the problems of medical indigency and uncompensated care because it was felt that failure to do so will result in decreased access to health care, both geographically and financially, for a growing number of Kansans. There is a need to educate policy makers, the public, and providers about potential results of failing to cope with access to health care on a timely basis. In order to implement this recommendation, committee has drafted HB 2014 which creates a Commission on Homeless and Medically Indigent. They urge for favorable enactment of this by the 1987 Legislature.

Recommendations on Proposal 25, i.e.,the special committee believes that no new vocational programs serving the mentally retarded nor any expansion in existing programs should be licensed or approved by the SRS until the community program includes residential services. Nor, should such programs be eligible for state financial assistance unless the program includes one or more levels of residential service. Further, the Joint committee on State Building Construction review requests for residential facilities submitted by community programs for the mentally retarded to the Joint Committee. Further, that authority be given to those counties that choose to increase their support of mental retardation services above the present statutory maximum tax levy. HB 2016 has been prepared to implement this recommendation.

Conclusions and recommendations from Proposal 27, i.e., special committee on Public Health and Welfare from Interim concluded the homeless cannot be put in a neat profile. Homeless are young, old, men, women, children, and combinations of all these. Private social service providers were commended for their work in meeting the needs of their clients for food, shelter, and other needed assistance. No new state system was recommended, since the SRS is encouraged to maximize its resources. Strong efforts to continue supporting private and public sector providers was recommended. Further, they recommend the 1987 Legislature create a Commission to follow-up the work of this Special Interim Committee on Public Health and Welfare as it pertained especially to Proposals Nos. 24 and 27.

May it be noted Ms. Correll was unable to complete her briefing due to lack of time.

Meeting adjourned at 3:05 p.m.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

RE: PROPOSAL NO. 24 -- ACCESS TO HEALTH CARE FOR THE MEDICALLY INDIGENT*

The Special Committee on Public Health and Welfare was asked to attempt to determine the extent to which Kansas has a medically indigent population; to consider the impact on such persons of changes in federal and state programs and third party payor reimbursement; to review the initiatives developed by other states to assure access to health care for the medically indigent; to consider ways of assuring access for those who are unable to pay for necessary medical care through insurance, savings, or public programs, including the state's "medical only" program; and to coordinate the Committee study under Proposal No. 24 with the Statewide Health Coordinating Council study on access to health care.

Committee Activity

The Special Committee heard a number of conferees on various aspects of the problems a segment of society has in accessing the health care system. The growing problem of uncompensated care, the changing roles of Medicaid and Medicare, lack of access to health insurance, funding cutbacks, changes in health care delivery and reimbursement -- all are a part of the growing problem of assuring access to needed health care. The Committee reviewed reports and recommendations prepared by the Statewide Health Coordinating Council and the Kansas Hospital Association; studied the systems utilized in other states to secure access to care for the medically indigent; considered various methods of funding an expanded system of service for the medically indigent; reviewed the history and scope of Medicaid, MediKan, and Medicare; and identified major policy issues and options involved in securing access to health care for Kansans who, because they do not qualify for governmental programs, are uninsured or underinsured, or are unable to

* H.B. 2014 accompanies this report.

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pay for all or a part of their health care, can be classified as medically indigent.

In carrying out the Committee study assigned as Proposal No. 27, the members also studied a subset of the medically indigent, the homeless, and came to realize there is a growing number of persons in Kansas who lack access to health care services, to housing, to jobs, and to other opportunities to improve the situation in which they find themselves. It is suggested that the Committee Report on Proposal No. 27 in this volume be read in conjunction with this report.

Conferees who met with the Committee included representatives of: the Statewide Health Coordinating Council, the Kansas Medical Society, the Department of Social and Rehabilitation Services, Abilene Memorial Hospital, Asbury Hospital in Salina, Bethany Medical Center in Kansas City, St. Joseph Medical Center in Wichita, St. Catherine Hospital in Garden City, the Girard District Hospital, the Kansas Hospital Association, the Kansas Association of Local Health Departments, the Kansas Childrens Service League, the Health Systems Agency of Northeast Kansas, the Department of Health and Environment, the Kansas Department on Aging, Kaiser-Permanente Health Maintenance Organization, Health Care Plus Health Maintenance Organization, Hospital Corporation of America, the Catholic Hospital Association, the Lawrence-Douglas County Health Department, the Association of Community Mental Health Centers of Kansas, the University of Kansas Medical Center, the American Association of Retired Persons, and the Wichita-Sedgwick County Head Start Program.

Background

Twenty years after the amendment of the Social Security Act by the addition of a new Title XIX providing for Medicaid and a new Title XVIII authorizing Medicare -- programs that were seen as guaranteeing access

to health care for the most vulnerable indigent and providing access to health insurance for the elderly and disabled, respectively -- the states find themselves confronting a serious problem in trying to assure access to needed health care for a growing number of their citizens. In 1985, a year in which health care costs in the United States reached $425 billion or 10.7 percent of the Gross National Product and government programs financed 41 percent of the per capita expenditure of $1,721, most state legislatures considered one or more bills concerning the medically indigent, and several states enacted legislation aimed at improving the lot of those with limited access to health care. In 1986, largely perhaps because of dwindling resources in states hard hit by rural economic and mineral production declines, fewer states enacted new programs related to the medically indigent, but a majority considered legislation or appointed a task force or commission to study the problem of medical indigency.

Medicaid. A number of the conferees who met with the Committee recommended that the problem of medical indigency be approached by maximizing federal dollars through the Medicaid program in which Kansas and the federal government cost share. However attractive the recommendation to maximize federal Medicaid dollars may seem, it is necessary to understand the limitations of Medicaid in order to test its viability. First, it is important to remember that Medicaid was not enacted to cover all of the poor. In general, Medicaid programs are limited to serving the poor who are aged, blind, or disabled and poor families with dependent children. Also covered, at the option of the individual state, are persons who are medically needy and categorically related to the aged, blind, or disabled, or to families with dependent children. Kansas has opted to include the categorically-related medically needy in its Medicaid program since its inception. There have always been a significant number of persons who could not become eligible for Medicaid regardless of their poverty level. For example, employable single adults, younger married couples with no children, and persons who are too young

to qualify as aged are usually not eligible for Medicaid.

Federal law mandates that states provide Medicaid coverage to all recipients of Aid to Families with Dependent Children (AFDC) cash grants; to recipients of Supplemental Security Income (the federal cash assistance program for the needy aged, blind, and disabled) or to the needy aged, blind, and disabled on the basis of more restrictive standards; to financially eligible pregnant women; to so-called "Ribicoff Children" born after September 30, 1983; to a limited extent, to families who lost AFDC cash assistance because of employment; to certain individuals who are ineligible for AFDC because of specific conditions such as the 1972 Social Security increases; to newborn children of Medicaid-eligible women; to children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act; to individuals who receive mandatory Supplemental Security Income supplements; to certain institutionalized individuals and blind or disabled individuals under 1983 standards; and to certain individuals who are eligible for Supplemental Security Income except for specified Social Security increases.

In addition, states have the option of covering the medically indigent who are categorically related to AFDC or Supplemental Security Income but who do not receive cash assistance and whose medical costs exceed a protected income level; "Ribicoff Children" who cannot qualify for AFDC because they are not "dependent" children; two-parent families with an unemployed parent; individuals who are eligible for cash assistance but who do not receive it; children under age 21 receiving institutional care; individuals receiving Home and Community-Based Services; and noninstitutionalized disabled children. Kansas Medicaid covers these optional groups.

Although Kansas essentially maximizes Medicaid dollars by covering those persons for whom coverage is an

option under federal law and regulations, there have been significant changes in both state and federal policy over the past five years as a result of budget constraints which have resulted in eliminating access to Medicaid for some individuals. Passage of the federal Omnibus Budget Reconciliation Act of 1981 impacted the AFDC program by eliminating cash and medical assistance eligibility for over 10,000 recipients through changes in eligibility criteria such as reducing the age limit for AFDC children from 21 to 18 and other changes. (Several of these changes have since been rescinded, but the remaining limitations continue to restrict cash and medical eligibility.) In 1983, Kansas implemented Job Search and Community Work Experience Program requirements in both AFDC and the General Assistance cash programs and in the AFDC-related medically needy program. Clients who fail to cooperate in these programs lose both cash and medical assistance eligibility for specified time periods. Also in 1983, AFDC needs standards were lowered for persons in shared living resulting in ineligibility for both cash and medical services for persons whose income exceeded the new standards. Additionally, Kansas has had to restrict the scope of Medicaid services and to institute cost saving measures which affect both providers of health care and Medicaid clients.

Of great significance in terms of maximizing Medicaid coverage of the poor nationwide is the failure of states to increase AFDC needs standards to keep up with inflation, which, in turn, has led to a decline in the ratio of the Medicaid population to the poverty population since eligibility for AFDC triggers Medicaid eligibility for about 61 percent of the Medicaid recipient population nationwide. Kansas is no exception. According to the Congressional Budget Office, in 1970, the Kansas needs standard for a family of four was $244 and in 1985 reached $422. While the percent of increase in current dollars was 73 percent, the change, measured in constant dollars, reflects a 36 percent decrease in the needs standard for a family of four. It should be noted that only three states did not reflect a decrease in the

needs standard measured in constant dollars during the same period.

Although Medicaid is often thought of as the principal means of financing care for those in poverty, Medicaid is, in 1986, principally a program which provides supplementary coverage for the aged and disabled who are eligible for and receive benefits under Medicare. In 1984, only about one-fourth of Medicaid expenditures nationwide went to pay for the eligible poor who were not eligible for Medicare. Three-fourths of Medicaid expenditures were payments for the care of individuals already covered by Medicare, including primary care services not covered by Medicare, long-term (nursing home) care, Medicare deductibles and co-payments, and Medicare Part B premiums. In Kansas, the adult care home component of the Medical Assistance budget has escalated from $41,000,928 in fiscal year 1976 to $100,949,564 in fiscal year 1986, a 170 percent increase. Adult care home expenditures significantly reflect services for the aged and disabled who are eligible for Medicare, but Medicare offers only limited coverage for long-term care following hospitalization.

General Assistance Medical. Kansas has traditionally operated a state-funded General Assistance cash assistance program, with a corresponding medical assistance component funded totally with state dollars. General Assistance provides cash and medical assistance (now known as MediKan) for those persons who are in poverty but who are ineligible for a federally-assisted program. The needs standard for General Assistance has traditionally been set at about 80 percent of the AFDC standard.

General Assistance has been subject to significant changes in recent years, which, in turn, have affected the extent to which the program reaches the medically indigent. The 1981 Legislature, in an effort to slow escalating Medical Assistance costs, eliminated the state-funded medically needy program beginning with fiscal year 1982. The General Assistance medically needy

program had provided coverage for those persons who did not qualify for a General Assistance cash benefit because of excess income but whose medical expenses resulted in spending down their income to the General Assistance protected income standard. Thus, General Assistance medically needy clients who had ongoing or emergency medical needs could qualify for medical assistance. In 1981 when the program was eliminated, the scope of services was the same as for Medicaid. At the time the program was terminated, over 2,000 recipients were dropped from the program.

In 1983, additional changes were made in General Assistance which affected both cash and medical eligibility. General Assistance was divided into two subprograms, General Assistance Unrestricted (GAU) and Transitional General Assistance (TGA). Families with children, persons age 51 or older, and the physically and mentally incapacitated were retained at the same benefit level on GAU. Employable single adults and married couples with no children were transferred to the TGA program. The lower standards for TGA resulted in about 2,000 persons losing cash and medical eligibility. MediKan services were also restricted in scope beginning in 1982.

Medicare. Although Medicare reimburses for about 45 percent of the health care expenditures of the aged, disabled, and those suffering from end-stage renal disease, Medicare does not cover prescription drugs nor long-term care, both of which represent high out-of-pocket costs for a portion of the Medicare population. Although only a small percentage of the elderly and disabled require long-term care, the cost of such care frequently must be supplemented by Medicaid and represents the largest, single component of the Medicaid budget. Thus, Medicare policies impact on Medicaid expenditures adversely and result in further reductions in the ability of Medicaid to cover the non-Medicare eligible indigent.

Medicare also requires that eligible individuals cover certain co-payments and deductibles before Medicare becomes the principal payor of covered services. For those individuals who do not have Medicare supplement coverage through insurance or through Medicaid, the cost share for which they are responsible may act as a disincentive to seek care at an earlier and less costly stage of an illness or disability. Additionally, health care providers testified they are seeing more individuals who are unable to pay the co-payments and deductibles or who can pay only a portion of such costs. Nonpayment or underpayment by Medicare-eligible individuals of hospital costs for which they are responsible is one component of uncompensated care.

In 1984, Medicare changed the method by which hospitals are reimbursed for Medicare-related patients, going from a fee-for-service payment based on retrospective costs to a prospective payment system known as diagnostic related groups. The prospective payment system, under which the reimbursement for service is fixed in advance by specific diagnosis, limits the ability of a hospital to shift the cost of indigent care to Medicare.

<u>Market Changes</u>. As the issue of the poor and health care has emerged in the 1980s as a challenge to the private sector and to government, a number of changes have taken place in the health care marketplace. One such change is the emergence of the uninsured as a factor. One source estimates that in 1983, nearly 33 million persons in the United States were covered neither by health insurance nor governmental benefit programs. Nearly two-thirds of the uninsured were employed or were members of a family in which the head of the household was employed and insured. While it is not reasonable to assume that everyone who has no third-party health coverage is medically indigent, a number of such persons are at risk if they experience a catastrophic illness or serious accident. Although those without health insurance include persons who are

at or below the poverty level, a number represent persons whose income is at or above the poverty level, but for whom health insurance, including dependent coverage, is too costly in comparison to other demands on income.

A number of factors have influenced the cost of health insurance, including rapidly escalating health care costs during the 1970s and early 1980s, increased mandated benefits, and technological advances in health care with the development of corresponding high-cost procedures. In spite of the number of uninsured, of the $371 billion in national personal health care outlay in 1985 (total spending excluding research, administration, public health, and construction costs) $113.5 billion or nearly 31 percent of the total was paid through private insurers. The federal government paid $112.6 billion or 30.3 percent of the total cost of personal health expenditures in 1985, and state and local governments spent $34.8 billion, leaving $105.6 billion to be paid by patients, largely as out-of-pocket expense. Unemployment, fueled by economic forces operating in the rural areas of Kansas along with decreased mineral production employment, appears to have constrained access to health care even further through loss of health benefits or decreased disposable income which can be diverted to health care.

As health costs and corresponding insurance costs have escalated, employers, employees, government, and insurers have become more interested in holding down costs. Deductibles and co-insurance are increasingly seen as ways to involve consumers in making economically rational health care choices. Employers are more concerned about paying only for the health care of their employees and are able to command economically sound coverage in a competitive marketplace. Alternative delivery systems have developed in the form of health maintenance organizations and preferred provider organizations and are forcing traditional providers to be more cost conscious and more competitive.

As a result of market changes, it is becoming more and more difficult for providers to shift the cost of uncompensated care (bad debts and charity care) to third-party payors and out-of-pocket payors. Since cost shifting represents the traditional system of transferring costs of uncompensated care, a dislocation in this system puts the medically indigent at higher risk for access. Co-payments and deductibles put health care providers at risk in collecting from consumers. The market forces and competitive environment that prevail today are particularly difficult for those providers, primarily hospitals, that serve a high percentage of the medically indigent. The Kansas Hospital Association identified the amount of uncompensated care delivered in 1984 as $75 million and indicated that the level would be higher in 1986.

Because Kansas employers include a large number of small employers for whom the increasing cost of health benefits represents a growing burden, health insurance as an employment-related benefit may become even less available unless some way can be found to enable small employers to purchase on a group basis.

Medically Indigent Programs -- Other States. In 1985, 34 of the states had either some type of program for care of the medically indigent in place or had enacted legislation authorizing a program that was not yet fully implemented. Eight states operated no programs that provided specific assistance to the medically needy. Several states operated programs that served only the populations located in a specific geographic area, and some states had only county-operated programs which varied across the state in terms of eligibility and coverage of services.

The most common form of assistance for the medically needy, outside of the inclusion of a medically needy component in the several states' Medicaid programs, in 1985, was similar to the Kansas General Assistance medical program -- MediKan. While Kansas included a number of state-funded cash assistance

recipients as automatically eligible for MediKan, many states with state-funded or state-county funded medical assistance programs for recipients of cash assistance either required a separate application or were more restrictive than Kansas in the persons or services covered by the medical program.

The Committee study revealed that in 1985 ten states made counties or other municipalities totally responsible for indigent care. In some instances, the responsibility of a local unit of government was limited as to the type of service which had to be covered. Sixteen states shared the responsibility of providing indigent care with counties or other units of local government. In several states, the services were limited to coverage of hospital costs, and in several other states the state participation in funding was triggered only when a specified level of local funding had been reached. In still other states, the county or other local unit of government had the option of participating in a state-assisted program. Eleven states accepted total responsibility for indigent care which generally was provided in the form of a general assistance or general relief medical-assistance program similar to the Kansas MediKan program prior to the exclusion of the medically-needy component in fiscal year 1982. Three states operated charity hospitals which provided hospital and certain other services for medically indigent citizens, and three states provided specific funding for charity care provided by university hospitals. Five states had adopted multiple-component approaches to care of the medically indigent by the end of 1985.

While the most common sources of funding for indigent care were state and local tax dollars, two states had created trust funds to finance all or a part of an indigent care program, five states had authorized an assessment on hospitals in order to create funding for one component of their medically indigent care programs, and one state required local health departments to provide expanded services for the medically indigent as one part of a multi-component program.

In 1985 and 1986, state legislatures considered, but did not adopt, legislation that would have created funding for medically indigent care through: (1) assessments on hospitals or other health care providers; (2) assessments on health insurance premiums; (3) creating a minimum "charity care" requirement to be met by hospitals or other providers; (4) creating "add-on" mechanisms for rate-setting; (5) mandating employer contributions; (6) earmarking revenues from cigarette taxes and motor vehicle fees or lottery and gambling revenues; and (7) creating an income tax checkoff for indigent care.

The Medically Indigent. The Statewide Health Coordinating Council identified the following subpopulations as being at high risk for medical indigency: adults between the ages of 60 and 65 who are not employed, who cannot afford adequate health insurance, and who are not eligible for Medicare; women between the ages of 45 and 65 who are either not in the work force or are in low-paying employment and who find cost a major deterrent to the purchase of adequate health insurance; black Kansans who, as a group, experience higher rates of poverty, unemployment, infant deaths, and illness than the white population; migrant and seasonal farm workers who do not have the resources to pay for adequate health care and who suffer a number of health problems as well as cultural and language barriers in accessing health care; the homeless (see report on Proposal No. 27); and displaced farmers who cannot afford to maintain health insurance and who are often ineligible for governmental programs because of resources.

Other groups at risk for access to adequate health care identified during the Committee study are persons who are eligible for Medicaid or MediKan who need a scope or intensity of services no longer available under the programs or who reside in an area in which provider access is severely circumscribed; pregnant teenagers who are not targeted for special services; and persons for

whom the spend down necessary to qualify for the Medicaid medically-needy component results in foregoing necessary health care in order to maintain housing and other essential services.

To illustrate the medically indigent in a more personal way, the medically indigent include: (1) the 62-year-old widow who has never worked, who draws Social Security on her deceased husband's account in an amount that is insufficient to purchase health insurance but is likely to make her ineligible for Medicaid ($375 to $475 a month), and who requires medication costing $100 a month; (2) the childless wife who works in a nursing home at minimum wage because her 25-year-old husband suffered a light stroke, cannot work, and needs therapy; (3) the motorcycle accident victim who had worked but who now faces a $10,000 hospital bill and whose needs standard is $120 per month but who is ineligible because he has income of $140 a month; (4) the epilepsy patient who was a Medical Assistance recipient until Vocational Rehabilitation worked with her and helped her find employment, whose condition has now worsened and who finds the medication she needs is no longer covered by MediKan; (5) the Medicaid recipient who cannot find a doctor to provide prenatal care; (6) the individual who cannot find a provider willing to accept him because he has large, unpaid medical bills and no medical card or health insurance; (7) the victim of Lupus who has recently been released from a mental hospital and now has no job to return to, who cannot afford health insurance, who has two small children, and who does not want to apply for "welfare"; (8) the farmer who needs eye surgery and cannot afford hospital or clinic care; (9) the woman, who does day work for several families, who receives no health benefits and who has developed insulin-dependent diabetes and cardiac problems which make it impossible to secure health insurance and whose husband's disability benefits keep them from qualifying for Medicaid; and (10) the 20-year-old who developed cancer whose family's insurance covered only a part of

the removal of his leg and whose family, headed by a 60-year-old father, has worked out payments projected 15 years into the future to pay the unpaid medical bills.

Identified Issues

The problem of how to assure access to necessary health care is a multifaceted one with no simple solution. Rather, there are a number of issues raised by the Committee's study which can be identified as noted below.

The state currently funds assistance programs which serve targeted groups as opposed to the Medicaid and MediKan programs which serve eligible populations. In recent years the Legislature has been approached by groups seeking specific state assistance programs -- the head injured, hemophilia victims, crippled childrens programs, maternal and child health initiatives. Which approach offers the best option for increasing the access of the medically indigent to health care?

The Committee received recommendations that health insurance coverage be increased through governmental subsidies for the poor and near poor, through subsidized risk pools which would provide access to health insurance for those unable to secure coverage in the market, through mandating that all employers offer health benefits to employees and their dependents, through imposing a tax on premiums, and through requiring employers to continue coverage of laid-off employees and their dependents. Would the state's costs, in the form of subsidies or foregone revenues be a more economic method of increasing health care access than expansion of Medicaid and MediKan? Would employer mandates drive more employers into self-insurance, thus placing them beyond the reach of insurance mandates? Can Kansas business remain competitive if it must bear state-imposed benefit burdens not imposed by all other states?

If the state is committed to assuring access to the medically indigent or to a targeted group thereof, should a new system of administration and delivery be created or should any additional population be subsumed in existing systems such as Medicaid, MediKan, and local health departments?

What are feasible short-range objectives for increasing access to health care? What are desirable long-range objectives?

Who should be targeted for improved access to health care -- the elderly, pregnant women and children, or those who suffer catastrophic illness or disease defined in economic terms?

What type of health care access is most desirable in terms of maximizing resources -- acute care or primary and preventive care?

Should the state be the sole nonfederal funding source for indigent care or should a joint state-county responsibility be developed?

What is the appropriate role of providers who are credentialed by the state in guaranteeing a specified level of health care for the medically indigent?

Are general or special taxes the appropriate vehicle for enhancing access to the health care system by the medically indigent?

Conclusions and Recommendations

The Special Committee on Public Health and Welfare concluded there is a problem which is rapidly approaching major proportions in securing access to health care for those Kansas citizens who lack private or governmental third-party coverage and who also lack the personal resources to pay for all or a part of their health care. Further, there are among Kansans those who

may join the classification of medically indigent if they experience a condition or disease that results in a need for other than routine, primary-care health care.

The Committee believes there are Kansans who are currently postponing needed health care because their resources are insufficient to pay for such care. Delay in securing care may result in an escalation of health care costs if it results in a functional disability or a catastrophic condition which could have been treated at a lesser cost in an earlier stage.

The members of the Special Committee conclude there are many issues which must be considered in the design of any system which will improve the access of rural and urban Kansans to necessary medical care. A careful analysis should be made of the issues identified by the Committee in order that the interests of the medically indigent, the providers of health care, and those who bear the costs of their own health care through insurance or self-pay may be weighed and balanced.

The Committee determined that any expansion of the state's financial commitment to access to health care for the medically indigent should be administered through existing administrative structures rather than through the development of a new structure.

The Committee is convinced that an additional commitment must be made to the indigent, and to the subset of the indigent represented by the homeless and the medically indigent.

The Special Committee, concerned about the homeless and indigent identified under Proposal No. 27 and the medically indigent identified under Proposal No. 24, requested an estimate of the impact of increasing the AFDC needs standard by $50 a month. It should be noted that increasing the needs standard would not only result in additional persons becoming eligible for AFDC cash assistance and, therefore, for Medicaid, but would allow

an increase in the protected income level for the medically needy which, pursuant to federal regulations, may be no higher than 133 1/3 percent of the AFDC needs standard.

However, the Committee concluded the cost to the state of implementing a $50 increase in the basic needs standards is not a feasible alternative at the present time. Additionally, the members considered proposing a recommendation that the General Assistance medically needy component of MediKan be restored at an estimated cost of $10,000,000 or at a lesser cost if the Medically Needy component were to be limited to targeted services or populations.

The Committee further concluded that serious consideration should be given to recognizing a role for local governments in providing access to medical care for their indigent residents and notes that some counties and districts currently support the availability of hospital care through mill levies.

Finally, the Committee recommends that continuing attention be given to the problems of medical indigency and uncompensated care because the members believe that failure to do so will result in decreased access to health care, both geographically and financially, for a growing number of Kansans. Additionally, there is a need to educate policy makers, the public, and providers about the potential results of failing to cope with access to health care on a timely basis.

In order to implement this recommendation the Committee has drafted H.B. 2014 which creates a Commission on the Homeless and Medically Indigent. The bill, which follows the model of the Social and Rehabilitation Services Review Commission created by the 1980 Legislature, provides for a commission composed of legislative and lay members and charges the members to consider those issues identified in this report and the report on Proposal No. 27. The members of the Special Committee on Public Health and Welfare recommend that

the 1987 Legislature enact H.B. 2014 at the earliest opportunity in order that the proposed commission may begin its work in a timely fashion and may prepare interim recommendations for the 1988 Legislature on two crucial issues facing the citizens of Kansas.

Respectfully submitted,

November 25, 1986

Sen. Roy Ehrlich, Chairperson
Special Committee on Public Health and Welfare

Rep. Marvin Littlejohn, Vice-Chairperson
Rep. Gary Blumenthal
Rep. Jessie Branson
Rep. Frank Buehler
Rep. Elaine Hassler
Rep. Melvin Neufeld

Sen. William Mulich
Sen. Joseph Norvell
Sen. Ben Vidricksen
Sen. Jack Walker

RE: PROPOSAL NO. 25 -- RESIDENTIAL FACILITIES FOR HANDICAPPED, ELDERLY, MENTALLY ILL, AND FUNCTIONALLY DISABLED ADULTS*

Proposal

Under the heading of Proposal No. 25, the Special Committee on Public Health and Welfare was directed to carry out a two-part study: (1) to review the current state regulatory programs that affect residential facilities for handicapped, elderly, mentally ill, and functionally disabled adults and to determine whether there are gaps in the state regulatory role or overlapping regulatory jurisdictions; and (2) consider ways to reduce the waiting lists for community facilities for the mentally retarded.

The request for the first part of the study submitted to the Legislative Coordinating Council asked that an interim committee: (1) identify the types of adult residential settings now regulated by the state; (2) identify any gaps in regulations; (3) study the appropriateness of the degree and type of state regulation; (4) review the location of responsibility for regulatory activities; and (5) consider other issues that affect the health and safety of adult residents.

The second part of the proposal asked the Council to assign a study of the problem of community centers for the mentally retarded and the extensive waiting lists connected therewith. From the context of the request, it appeared that the intent was to include both residential and vocational services within the scope of the study. However, the proposal, as assigned, was interpreted to be limited to the development of residential facilities for the mentally retarded.

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* H.B. 2015, H.B. 2016, H.B. 2017, H.B. 2018, and H.B. 2019 accompany this report.

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Committee Activity

The Special Committee devoted three days to hearing conferees on Proposal No. 25, reviewing state laws, reviewing applicable rules and regulations, considering issues associated with state regulation of private service providers and reviewing the Post Audit report "Private-Pay Rates for Adult Care Homes." Conferees who met with the Committee included: the Executive Director of the Kansas Association of Homes for the Aging; a representative of Presbyterian Manors of Mid-America; representatives of the Sedgwick County Department of Aging; a representative of the Kansas Health Care Association; the Director of Kansas Alternatives for Senior Housing; the Director of Share-a-Home and Orchard House; representatives of the Departments of Health and Environment and Social and Rehabilitation Services; a parent advocate of a quadriplegic son; a representative of St. Patrick's House; an individual who has operated various service programs for the elderly; a representative of the Advisory Committee on Employment of the Handicapped; a representative of the Legislative Division of Post Audit; a representative of Community Living Opportunities; the Executive Director of the Johnson County Mental Retardation Center; a representative of the Kansas Association of Rehabilitation Facilities and of Sheltered Living; a representative of the Kansas Association for Retarded Citizens; the Executive Director of the Topeka Association for Retarded Citizens; the mothers of four handicapped young adults; an individual participating in the Occupational Center of Central Kansas work-activity program who is on a waiting list for residential services; and a representative of Mental Health and Retardation Services.

Background -- Regulated Adult Facilities

Boarding houses and rooming houses are licensed by the Department of Health and Environment pursuant to the food service and lodging statutes found at K.S.A. 36-501

et seq. Rooming houses are defined as facilities in which sleeping accommodations are made available to eight or more transient or permanent guests. Boarding houses are defined as facilities that maintain sleeping accommodations for eight or more paying guests which also maintain facilities for the service or preparation of meals for the guests. Neither rooming houses nor boarding houses are licensed to provide assistance or supervision for the adult persons who reimburse the licensee for sleeping accommodations or meals, or both. Thus, rooming houses and boarding houses are not licensed to provide either assistance with daily living or supervision of the guests. Rooming and boarding houses having sleeping accommodations for fewer than eight guests are not regulated by the state.

The Department of Health and Environment also licenses various types of facilities under the Adult Care Home Licensure Act, K.S.A. 39-923 et seq. Three levels of licensing reflect the traditional concept of an adult care home or nursing home, i.e., the skilled nursing home which provides skilled nursing care for residents requiring licensed nursing care and treatment; the intermediate nursing care home, also known as an intermediate care facility, which provides supervised nursing care for residents who need traditional nursing services; and the intermediate nursing care home for the mentally retarded, also known as an intermediate care facility for the mentally retarded, which provides supervised nursing care and active treatment for mentally retarded residents. At the time of the Committee review, there were 57 skilled nursing homes, 293 intermediate care facilities, and 22 intermediate care facilities for the mentally retarded licensed by the Department of Health and Environment. The three medical-model categories of adult care homes noted above are all eligible for reimbursement under the state-federal Medicaid program and must meet federal standards as well as state licensing requirements to be eligible for reimbursement for Medicaid or, in the case of skilled nursing homes, for limited Medicare reimbursement.

Also subject to licensure under the Adult Care Home Licensure Act are intermediate personal care homes, boarding care homes, and one- and two-bed adult care homes which, in general, represent a nonmedical model of residential service.

Pursuant to statute, intermediate personal care homes may provide personal care or "simple nursing care" for residents. The term "simple nursing care" has been interpreted to mean personal-care services such as assistance with bathing, dressing, eating, transportation, etc. There was one facility licensed as an intermediate personal care home at the time of Committee review. However, there are intermediate personal care beds licensed in facilities that also provide another, higher level of care.

Boarding care homes, as defined in the Adult Care Home Licensure Act, are facilities that provide supervision for adults who are ambulatory and essentially able to manage their own affairs. There were 28 boarding care facilities licensed at the time of the Committee study.

One- and two-bed adult care homes may provide any level of adult care that the facility is licensed to provide. Generally, one- and two-bed facilities are operated by an individual in his or her own home. There were 46 licensed facilities at the time of the Committee study. The majority of licensed facilities provided simple nursing care, i.e., personal-care services and, in some instances, supervision.

The Department of Social and Rehabilitation Services regulates congregate living homes, one- to 15-bed community living programs, and five- to 40-bed resident care facilities. During the Committee study, the category of adult facility formerly known as congregate living homes was subsumed into a new category of facility known as resident care facilities as authorized by action of the 1986 Legislature.

Adult family homes are registered by the Secretary of Social and Rehabilitation Services pursuant to K.S.A. 39-1501 et seq. This category of facility, which is also referred to as adult foster care, provides care to one or two clients in the registrant's private residence. By statute, an adult family home does not provide nursing care but may assist a client with the taking of medication and with such daily activities as eating, bathing, and dressing, with a brace or walker, or with transferring from wheelchairs. The adult family home statutes are unique in that the requirements to be met to achieve registration are set out in the statutes rather than being set by rule or regulation.

Community living programs providing residential services to one to 15 adults are licensed by the Secretary of Social and Rehabilitation Services pursuant to K.S.A. 75-3307b and generally serve the mentally retarded or the mentally ill. Under the general heading of community living programs are: (1) group living; (2) semi-independent living; (3) independent living; and (4) respite care. Community living programs, which are frequently associated with a licensed work-activity center for the mentally retarded, provide assistance in daily living and training aimed at improving the resident's living skills. Community living programs are licensed only if they receive or have received state or federal funding.

Resident care facilities have been licensed by the Secretary of Social and Rehabilitation Services since July 1, 1986, the effective date of Chapter 324, 1986 Laws of Kansas which amended K.S.A. 75-3307b. Now included in this category of facility, which provides assistance, supervision, and limited assistance with the taking of medication for five to 40 residents who are mentally ill, mentally retarded, or otherwise handicapped, is the category of facility which previous to September 1, 1986, was known as a congregate living home. If a resident care facility serves eight or more persons, it may not be licensed by Social and Rehabilitation Services unless the Secretary of Health

and Environment has approved the facility as meeting the licensing standards for a lodging facility promulgated pursuant to the Food Service and Lodging Act.

Concepts of services for the elderly and handicapped have changed in the last decade to encompass a range of nonmedical support services which serve as alternatives for the elderly or handicapped who are functionally disabled, e.g., who require some assistance with the activities of daily living, or who require supervision of medication, personal hygiene, etc. Traditionally, such persons could remain in their own homes without receiving the services they need, could move to an adult care home, or could move in with their families. Today, a range of options is available in some areas for those who are functionally disabled. Such persons may choose to share a family home with others; may receive assistance or supervision in their own homes from outside providers; may move into a residential setting in which one or more persons provide some assistance with bathing, dressing, or other activities of daily living; may opt for living in a residential setting in which supervision is the primary service provided; or may choose a congregate living setting. In general, the developing options in residential services encompass a range of nonmedical support services which can be characterized as providing assistance or supervision for adults.

Currently, residential facilities that provide assistance or supervision for adults and that do not serve the mentally ill or mentally retarded must either meet the licensing requirements for intermediate personal care facilities or boarding care facilities licensed under the Adult Care Home Licensure Act or must find other ways to provide the services needed by residents. Some facilities that offer assistance or supervision to residents have developed in-house home health agencies to provide services, because the physical facility requirements and staffing requirements for intermediate personal care facilities are too expensive and are not needed by the residents. Conferees indicated they had

been forced to change the type of services they had planned to provide for elderly self-care, ambulatory, or semi-ambulatory residents because meeting the adult care home rules and regulations would make the cost of residential services too expensive for the clients they hoped to serve.

Several conferees gave examples of the difficulty they had experienced in finding affordable, appropriate assisted-living, residential placements for family members or for themselves, and several conferees who are operating or who have operated boarding care homes in small, rural communities testified to the restrictions placed on their operations by state regulations. It was noted that the lack of state and federal financial assistance for personal-care and supervised-care residents pushes people into more expensive, medical-model nursing homes (intermediate care facilities) sooner than necessary because of depleted financial resources. A number of conferees proposed that residential facilities offering personal-care services and supervision be regulated in a way that recognizes the population of elderly or physically handicapped who are not in need of nursing care but who do need assistance with one or more activities of daily living, or who need supervision of personal hygiene, medication, or nutrition.

Conclusions -- Regulated Adult Facilities

The Committee concluded there are currently several state regulatory systems in place that affect residential settings in which adults who do not require a medical model of care and who are not related by blood or marriage to the operator may reside.

Essentially, intermediate personal care facilities, boarding care homes, and one- or two-bed facilities licensed under the Adult Care Home Licensure Act; adult family homes registered pursuant to K.S.A. 39-1501 *et seq.*; community living programs licensed pursuant to

K.S.A. 75-3307b; and resident care facilities licensed under 75-3307b provide assistance with daily living or supervision, or both, for the adults who reside therein. In terms of statutory authorization, each of the above facilities may serve elderly, handicapped, mentally retarded, or mentally ill adults. In fact, community living programs generally serve the mentally retarded and resident care facilities generally serve the mentally retarded or the mentally ill. Some adult family home clients are higher-functioning mentally retarded. Although the level of service provided by such facilities is generally personal care (assistance) or supervision, the statutory scheme under which they are regulated varies from the minimal (adult family homes) to the complex (intermediate personal care and boarding care homes).

There appear to be overlapping statutory provisions relating to residential settings for adults who require personal care or supervision. The statutorily authorized services that may be provided by a registered adult family home are generally similar to those which may be provided by a licensed intermediate personal care home or a licensed boarding care home. There is a statutory overlap between the definition of boarding care home as found in the Adult Care Home Licensure Act and the definition of adult family home found in K.S.A. 39-1501. In both settings, the adult resident is to be essentially capable of managing his own care and affairs. There is some overlap in the definition of intermediate personal care home in the Adult Care Home Licensure Act, which refers to "simple nursing care," a term which has been interpreted to include personal-care services such as assistance with bathing, dressing, eating, etc., and the services which may be provided by an adult family home as set out in the statute. Additionally, several of the statutes (adult family home and residential living facility) authorize limited assistance with the taking of medication even though the services to be provided by such facilities represent a nonmedical model of service.

There appears to be no overlap of regulatory functions as applied to _state_ regulation of residential settings that are _medical_ in orientation, _i.e._, skilled nursing homes, intermediate care facilities, and intermediate care facilities for the mentally retarded, although there are two agencies -- the Department of Health and Environment and the State Fire Marshal -- involved in state licensing. There are overlapping regulatory functions that arise because such facilities are reimbursed under the state-federally funded Medicaid program. In order to participate in Medicaid, the medical model facilities must be certified as meeting Title IX standards and the Medicaid agency (Social and Rehabilitation Services) must review medical necessity and the quality of care provided to Medicaid-eligible residents in such facilities.

The Committee concluded that any review of medical-model facilities and the reimbursement rates applicable to such facilities should be conducted in a separate study. The Committee does express concern about the rate increases that private-pay residents of intermediate care facilities have experienced recently and commends the Legislative Post Audit staff on the audit report "Private-Pay Rates for Adult Care Homes." The Committee concludes the subject of private pay rates is one that needs to be addressed by the Kansas Legislature.

The members of the Special Committee on Public Health and Welfare conclude that state regulation as presently structured, may impede the development of nonmedical-model residential services for adults. This conclusion is supported by testimony presented to the Committee and by the fact that in two instances (adult family home regulation and residential care facilities) the Legislature has chosen to remove certain types of facilities that were subject to regulation under the Adult Care Licensure Act from the purview of that act.

The Committee also concludes that nonmedical adult residential facilities should not be regulated under the

same laws and to the same degree as are medical-model facilities. Any regulation of residential settings in which personal care or supervision is provided to the residents should represent the minimum regulatory structure that is consistent with the health and safety of the residents.

Recommendations -- Regulated Adult Facilities

The Committee recommends that the policy of the state of Kansas be one of encouraging the development of alternative services for elderly and handicapped adults who are not in need of medical-model residential services but who do require assistance or supervision in carrying out activities of daily living. To this end, the Committee recommends that the level of state regulation of such facilities be the minimum that is consistent with protecting the health and safety of the residents and consistent with protection of residents from abuse or exploitation.

The Committee recommends that the authority for regulation of adult residential facilities be located within the state agency with primary responsibility for the type of functional disability which gives rise to specific residential services. To accomplish this recommendation, the Committee further recommends that K.S.A. 75-3907b remain the statutory authorization for the regulation of facilities that serve those persons who require adult residential services primarily as a result of mental retardation or mental illness, and that new legislation be enacted which provides for the regulation of those facilities currently identified as intermediate personal care homes, boarding care homes, and adult family homes which serve primarily the elderly and physically disabled. H.B. 2017 and H.B. 2018 have been prepared by the Committee to implement this recommendation.

H.B. 2017 creates a new Adult Residential Living Facilities Act under which places which provide personal services or supervision of activities of daily living for adults who reside therein would be licensed by the Secretary of Health and Environment upon meeting the requirements set out in the bill. H.B. 2017 also amends various other statutes to delete references to facilities currently licensed under such statutes or to reference the new act.

H.B. 2018 transfers the responsibility for registering adult family homes from the Secretary of Social and Rehabilitation Services to the Secretary of Health and Environment to be consistent with the Committee recommendation relating to the primary roles of the agencies.

The members of the Special Committee believe that the standards to be met by nonmedical adult residential facilities that serve the elderly and physically handicapped should be minimal and should relate only to those standards necessary to protect the health and safety of residents. Thus H.B. 2017 enumerates those standards that are to be developed by the Secretary of Health and Environment through the adoption of rules and regulations. At such time as the regulatory agency determines that any additional standards are appropriate or necessary to protect the health and safety of residents, recommendations should be made to the Legislature.

Further, the Committee recommends that exemptions from one or more regulatory standards be authorized for a specified period of time and in specified circumstances in order to foster the development of "pilot projects" that reflect new ways to serve functionally disabled elderly and physically handicapped populations. This recommendation is reflected in H.B. 2017.

Finally, the Committee recommends that no state regulation extend to those facilities in which adults voluntarily live together and in which no services are

provided to the residents, except as regulation is currently reflected in the Food Service and Lodging statutes applying to rooming houses and boarding houses.

The Committee recommends that the appropriate committees of the Legislature consider H.B. 2017 and H.B. 2018, and that such legislation be enacted by the 1987 Legislature.

Background -- Residential Facilities for the Mentally Retarded

Residential facilities for the mentally retarded, regulated pursuant to K.S.A. 75-3307b, have been described in an earlier section of this report as encompassing community living programs providing residential services to one to 15 adults and including supervised group living, semi-independent living, independent living, and respite care. Additionally, intermediate care homes for the mentally retarded, which provide care and training for more severely handicapped or multiply-handicapped adults, are licensed pursuant to the Adult Care Home Licensure Act. The latter are also subject to federal certification since they qualify for reimbursement under Medicaid.

The Committee received recommendations from conferees that state licensing regulations applicable to small, 15-bed-or-less, intermediate care facilities for the mentally retarded reflect the same requirements as do federal certification standards. It was further recommended that those licensing requirements that relate more appropriately to nursing homes serving the elderly or to large intermediate care facilities for the mentally retarded be deleted from the licensing regulations as they apply to small, 15-bed-or-less facilities.

Many conferees who met with the Committee expressed concerns about the gap between available community living programs for the mentally retarded and the demand for such facilities. It was stressed that waiting lists

exist for community living programs and that acceptance for vocational and other community services may be dependent on the availability of residential programs. The concerns about present waiting lists are even more urgent when viewed in conjunction with the potential demand for residential programs created by individuals who will be exiting special education programs and who will need residential placements and other community services.

As of November, 1986, 812 adults seeking some type of community mental retardation services had applied for services and had been accepted as in need of services, but no placement had been made.

Conferees stressed the need for additional funding for community programs for the mentally retarded and recommended that the state encourage community programs to be innovative in service delivery rather than simply increasing "the same old systems." Other recommendations included earmarking state dollars for staffing support, earmarking funds from the gasoline tax for mental retardation services, using state dollars from the State Institutional Building Fund for construction of group homes to be operated by community providers, and increasing the funding distributed to community programs pursuant to Chapter 245, 1986 Laws of Kansas.

Conferees who met with the Committee expressed concern about the appropriation action taken by the 1986 Legislature specifying that funding for special purpose grants for mental retardation be utilized to contract with community providers to develop and provide services to individuals currently residing in a state mental retardation facility and considered appropriate for community services. It was noted that this action has resulted in the development of two waiting lists for community services.

Conclusions -- Residential Facilities for the Mentally Retarded

The Special Committee on Public Health and Welfare concludes that it is inappropriate to move residents who currently are being served in state residential facilities to the top of community-program waiting lists through the provision of special funding which allows the development of services for these specific individuals. Rather, the Committee supports a single waiting list for community services, with potential clients to be admitted to community programs on the basis of appropriateness of service and position on the waiting list.

The members of the Special Committee on Public Health and Welfare believe that, even in a year in which state resources are limited, there is a need to expand state financial support for community services for the mentally retarded and considered various recommendations for increasing funding. The Committee concluded that assessing the State Institutional Building Fund for construction of group homes at the community level offers the most opportunity to increase the state commitment to community residential programs. Additionally, the Committee believes that the authority to increase county mill levies above the current statutory maximum should be available to those counties that choose to increase support of community residential services.

Finally, the Committee concludes that the method of allocating state financial assistance to community programs developed by Chapter 245, 1986 Laws of Kansas, should be clarified and continued.

Recommendations -- Residential Facilities for the Mentally Retarded

The Committee believes that no new vocational programs serving the mentally retarded nor any expansion in existing programs should be licensed or approved by the

Secretary of Social and Rehabilitation Services until the community program includes residential services. Nor should such programs be eligible for state financial assistance unless the program includes one or more levels of residential service. This conclusion is based on the belief that available resources should be used prudently and that the development of work-site or vocational training programs should be accompanied by residential services in order that the gap in residential programs not be exacerbated. H.B. 2015 amends two statutes to place such limitations on the approval and licensing of new vocational programs and the expansion of existing programs.

The Special Committee on Public Health and Welfare recommends that the Joint Committee on State Building Construction review requests for construction funding for residential facilities submitted by community programs for the mentally retarded to the Joint Committee. The Joint Committee should consider adding the construction of community-based group homes for the mentally retarded to those construction projects considered for funding from the State Institutional Building Fund.

The Committee recommends that authority be given to those counties that choose to increase their support of mental retardation services above the present statutory maximum tax levy to do so, subject to a protest vote by electors of the county. The Committee has prepared H.B. 2016 to implement this recommendation.

It is recommended that the provisions of Chapter 245, 1986 Laws of Kansas, be extended until 1990 in order that the allocation of state financial assistance to community mental retardation programs be continued on the basis of population served. H.B. 2019 amends K.S.A. 1986 Supp. 65-4411 to provide that the Kansas Community Mental Retardation Facilities Assistance Act be extended through June 30, 1990. The bill also provides that a client accepted by a facility after July 1, 1987, shall only be considered a full-time equivalent client for purposes of qualifying for state assistance

if such client was accepted by the facility on a first-come, first-serve basis. Finally, H.B. 2019 sunsets K.S.A. 1986 Supp. 65-4414, a statute which constitutes a "hold-harmless" provision in the event state assistance is not sufficient to pay all facilities the minimum amounts requested, on July 1, 1989.

The Committee also recommends that, even though the 1987 Legislature will face difficult decisions relating to the funding of state programs, consideration be given to expanding state funding for community mental retardation programs in order that individuals not be forced to "mark time" in receiving services nor lose the benefits of special education training through waiting for available services.

Respectfully submitted,

November 25, 1986

Sen. Roy Ehrlich, Chairperson
Special Committee on Public Health and Welfare

Rep. Marvin Littlejohn, Vice-Chairperson
Rep. Gary Blumenthal
Rep. Jessie Branson
Rep. Frank Buehler
Rep. Elaine Hassler
Rep. Melvin Neufeld

Sen. William Mulich
Sen. Joseph Norvell
Sen. Ben Vidricksen
Sen. Jack Walker

RE: PROPOSAL NO. 27 -- HOMELESS AND INDIGENT SERVICES

Proposal No. 27 directed the Special Committee on Public Health and Welfare to: determine whether there is a significant homeless population in Kansas; consider the location of any such population, the programs available to serve such population, and the causes leading to homelessness; and review and make recommendations regarding any gaps in publicly funded services for the homeless and other indigents.

Background

In the months preceding the creation of the interim Special Committee on Public Health and Welfare, the national and local media carried stories of the homeless -- "street people" -- who, for whatever reasons, became visible in city streets and were captured vividly on the front pages of newspapers and on video tape for rural and urban citizens of the nation to see. "Bag ladies" and "stubbled-faced, alcoholic men" seemed to be the characters the media recorded, and they quickly came to represent the stereotypical homeless person. From that description, it was easy to conclude that these persons were homeless by choice and, for the most part, were happy with the freedom associated with life on the streets, except, perhaps, for life during the winter months in the northern parts of the country.

When the lights of the television cameras turned to other stories and the newspaper photographers focused their lenses in other directions, the visions of the homeless previously displayed did not disappear from the consciousness of those who had seen, read, and heard of their plight. In fact, the reality of the homeless spread across the nation as even people in small towns began to see their own local variations of a problem which had seemed confined mostly to big cities and to the persons identified above. Homelessness, a condition defined previously as remote

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and self-induced, began to attract the attention of local politicians and social service organizations who were confronted with people of many descriptions but all characterized by the condition that can be described as temporarily homeless.

Material presented to the Legislative Coordinating Council in support of a study of the homeless in Kansas referenced the media presentations and attention, noted that the homeless population has become a drain on public and private social service agencies, and that private citizens are affected as the number of nonproductive individuals increases in a community and instances of vagrancy and instability arise. By extrapolating from national data, the materials speculated that there might be 3,000 to 30,000 homeless in Kansas. That lack of specific information regarding the homeless, i.e., their number, their makeup, their needs, led the Council to direct the Special Committee to identify the homeless and to determine if there are gaps in the "safety net" for the homeless and other indigents.

Committee Activity

In the course of its deliberations on Proposal No. 27, the Special Committee on Public Health and Welfare held hearings in Wichita and in Topeka and received testimony from conferees representing many different geographical areas of the state who spoke for public and private social service agencies and for various religious organizations. Included among those addressing the Committee were representatives of: the Department of Social and Rehabilitation Services; the Topeka Housing Authority; the Topeka Rescue Mission; the Wyandotte Family Shelter; the Alliance for the Mentally Ill of Sedgwick County; the Bryant Shelter, Kansas City; Everywoman's Resource Center, Topeka; the Red Cross of Topeka; the Salvation Army -- Lawrence, Topeka and

Wichita; the Sedgwick County Mental Health Department; Let's Help, Topeka; the United Community Services of Johnson County; the Shelter for the Homeless, Wichita; St. Anthony's House, Wichita; the Episcopal Social Services, Wichita; the United Methodist Urban Ministries, Wichita; the Mulvane Christian Church; Interfaith Ministries Sheltered Advisory Committee, Wichita; the Salina Gospel Mission; the United Methodist Western Kansas Mexican-American Ministries -- Garden City, Liberal, Dodge City, Ulysses, Johnson, and Satanta; the Emmaus House, Garden City; the Community Kansas Family Shelter, Hays; the Souls' Habor Mission, Baxter Springs; the Wesley House, Pittsburg; Emergency Social Services for Midway Kansas Chapter of the American Red Cross, Wichita; United Way of Wichita; and from two homeless persons.

Numbers of Homeless. Nationwide, a 1984 count of the homeless by the Department of Housing and Urban Development concluded that there were approximately 250,000 to 350,000 homeless persons in the United States. Upon its release, the study was soundly criticized for understating the real number of homeless, with some advocacy groups estimating as high as three million homeless persons. However, a recent study by a Harvard professor, using a different methodology than that used by Housing and Urban Development, has confirmed that there are approximately 350,000 homeless persons in the United States (1985).

The conferees on Proposal No. 27 were nearly unanimous in their comments that the number of homeless in Kansas is not known and cannot be easily determined. Representatives of social service agencies noted that they have spent their time providing much needed services to the homeless and have not attempted to count them for the purposes of gathering statistics. (Some conferees did indicate that there is a need to count the homeless in order to provide some accountability to those who provide the funding for the services rendered.) Rather, any count that exists is based on beds used or meals served over a period of

time. There seems to be agreement that no unduplicated count of the homeless is available for any area of the state. Nevertheless, the following data represent "approximations" of the number of homeless in different regions of the state on the date testimony was given by the various providers in the areas. The data may not be comparable, in that some of the numbers reported are seasonal, others annual, some may represent homeless Kansans, while others may be transients temporarily in the state.

- -- Liberal, 75 to 100 persons
- -- Garden City, 50 to 75 persons
- -- Dodge City, 25 to 50 persons
- -- Ulysses, Johnson, and Satanta appear to have no significant problem
- -- Crawford County, 120 or more persons
- -- Baxter Springs, 20 to 30 persons monthly
- -- Johnson County (Olathe/Southwest), 200 persons
- -- Wichita, 100 to 300 persons on any given day
- -- Sedgwick County, 1,500 to 2,000 homeless mentally ill
- -- Metropolitan Kansas City, 3,000 to more than 5,000 persons

The lack of a specific body count notwithstanding, nearly all conferees concluded that there is a substantial number of homeless in Kansas, that the number appears to be growing larger, and that services provided in 1986 have increased over those provided the previous year.

Profile of the Homeless. The conferees from all of the areas of Kansas were quick to point out to the Committee that the stereotype of a homeless person as a "bag lady" or "alcoholic" is inaccurate today and, perhaps, was never an adequate description of the homeless population. For example, statistics provided by the Family Shelter operated by the Wyandot

Mental Health Center, Inc., disclosed the following profile of its clients, using actual data for the period January 1, 1986, through September 30, 1986, and estimated data through December 31, 1986.

Total served, 868 (100%)
Individuals, 606 (69.8%)
Families, 262 (30.2%)
Previous Kansas City, Kansas, address, 279 (32.1%)
Previous state of Kansas address, 42 (4.9%)
Out-of-state address (including Missouri), 547 (63.0%)

Statistics gathered by the Emergency Assistance Center of Johnson County corroborate the Kansas City findings. Based on services to approximately 200 homeless, the agency found the homeless to be 50 percent two-parent families with minor children; 30 percent single-parent (usually female) families with minor children; and 20 percent single adults and older teenagers, both male and female.

Data provided by the Sedgwick County Department of Mental Health indicated a very high number of mentally ill persons among the homeless population of that county. However, while other reports were received that indicated the chronically mentally ill are a part of the homeless population, no area of the state reported the chronically mentally ill as constituting a significant part of the homeless as did Sedgwick County.

Those reporting a profile of the homeless from western and southwestern Kansas described a population comprised largely of single males from 17 years of age through 50 years of age attracted to the area, for the most part, by the lure of employment in the meat packing industry. About 60 percent of the homeless in these areas of the state are citizens with the remaining 40 percent being undocumented aliens. There appears to be a subgroup of the homeless made up of families

who have accompanied the male head of the household in search of employment.

In summary, all the conferees described a homeless population different from the stereotype and indicated that the number of women and children found in the homeless populations seems to be increasing.

Causes of Homelessness. No conferee attempted to give a priority listing of the causes for homelessness. Rather, the Committee was presented a laundry list of events and circumstances in the lives of the now homeless which at least contributed to their present state. Among the reasons presented were: unemployment; eviction by landlord; eviction by parents; divorce; discharge from a mental hospital; illiteracy; lack of job skills; alcoholism; domestic violence; farm failure; worn-out welcome with friends who have provided shelter; awaiting employment; awaiting receipt of public assistance; personality syndrome of chronic dependency; lack of available and affordable housing; and unaffordable or unavailable day care.

Availability of Resources for the Homeless. The Wichita and Sedgwick County areas seemed to have the greatest demand for temporary shelter facilities for the homeless, and available shelters have been filled nearly to capacity, even during the summer months.

Shawnee, Douglas, Wyandotte, Saline, and Johnson counties seem to have sufficient shelter space to meet the present demand, except that nearly all saw a need for increased shelter space for families. The more rural areas of the southeast and the southwestern urban areas seem to have adequate temporary shelter as well.

In all areas of the state, the conferees clearly identified a shortage of permanent housing and affordable permanent housing as problems contributing to the perpetuation of the homeless condition. Particularly, the shortage of housing seems to work a

greater identifiable hardship in the Dodge City and Garden City areas because many of the homeless are employed or expecting employment shortly, but simply cannot find housing. Further, the lack of affordable housing seems to prolong the homeless condition of female heads of households since the cost of housing, including utilities, takes up too large a percentage of the financial resources available, whether such resources are from employment or public assistance.

Representatives of the Division of Income Maintenance of the Department of Social and Rehabilitation Services did inform the Committee about a project initiated in cooperation with the federal Department of Housing and Urban Development. Since December, 1985, a Section 8 Housing program has been implemented to house 15 homeless families in Wyandotte, Leavenworth, and Johnson counties, with 100 percent federal funding. (The average housing assistance payments for the first 15 households was $292 per month.) That program has received additional funding to allow monthly housing assistance to 19 more homeless families. By the end of calendar year 1986, the Department anticipates receiving authorization and funding to expand the homeless assistance program to a total of 84 households in the three-county area.

Because there has been widespread interest in the pilot project and because the pilot project has been successful in Kansas, it is possible that it could be expanded nationwide. However, even if federal assistance for housing the homeless is not expanded, it is planned that any additional funds provided to Kansas could be used for homeless programs in other targeted areas of need in the state.

Regardless of whether conferees reported sufficient shelter space or a shortage of beds, all agreed that the winter months could bring additional homeless persons and families to their attention for services. Moreover, the providers expressed great concern for those persons, not currently homeless, who are living such a precarious

existence that one more unpaid utility bill or another missed rent payment would put them on the streets and on the doorsteps of the over-burdened social service system. Exacerbating the problem for the providers is the knowledge that most of the homeless have chosen to use their eligibility for Transitional General Assistance provided by the state during the summer months and will have no cash financial support during the winter.

Among those homeless looking for employment, conferees noted that the lack of transportation can be a serious deterrent to finding a job. The problem exists for those who must depend upon public transportation to get to work as well as for those travelling from place to place in search of employment whose vehicle has broken down short of the job location. Since the social service providers' resources are already stretched by the provision of food and shelter, there is little or no money available for transportation expenses.

For some two-parent families and certainly for most single-parent families among the homeless, the cost of child care can and does extend the period of homelessness because the parent is prevented from even seeking employment. In those cases where employment is found, jobs acquired by the homeless tend to pay at the minimum wage level and, thus, provide insufficient income to afford most available day care services.

Finally, regarding the mentally ill among the homeless, some conferees explained their homelessness in terms of an inadequate system of care in which the mentally ill revolve through institutions and community programs and institutions. It was suggested that adequate funding and outreach programs could help remove the mentally ill from the streets and from this cycle. Conferees also indicated that a percentage of the chronically mentally ill choose not to participate in community programs even when services are scheduled for them.

Asked about the possible role of the state in helping the homeless and those with insufficient food, conferees were nearly unanimous in recommending state assistance to local social service agencies, in their support of the Emergency Assistance Program offered by the Department of Social and Rehabilitation Services and of the need to increase funding for Emergency Assistance, and of the need to provide literacy or job training for those whose skills are inadequate for today's society.

Conclusions and Recommendations

The Special Committee on Public Health and Welfare concludes that the homeless cannot be reduced to a neat profile. Rather, any definition of the homeless can only be accurate if it ignores the stereotypical "bag lady" and "alcoholic" and admits:

-- that the homeless are a heterogeneous group of young and old, men, women, children, and combinations of these, in nuclear families and in single-parent families headed by some men but mostly by women;

-- that regardless of the profile, those who make up the homeless do so in large part by circumstance and not by choice;

-- that most homeless persons would choose employment over unemployment;

-- that most homeless lack the necessary educational (literacy) or vocational (job) skills to acquire or maintain employment;

-- that permanent housing would be chosen by the homeless over shelter living if housing (including utilities) were available and affordable; and

-- that social service resources used to provide or to create permanence are better expended than if spent on social services for transient populations.

The Committee commends the private social service providers for their work in meeting the needs of the homeless and recommends that they continue efforts to meet the immediate needs of their clients for food, shelter, and other types of assistance. The Committee does not recommend any new state system or program of services to the homeless at this time. Rather, the Department of Social and Rehabilitation Services is encouraged to maximize its resources, both human and financial, by supporting the efforts of private and public sector providers. The Committee appreciates the fact that Social and Rehabilitation Services has clarified with the providers the initial requirements for seeking public assistance, i.e., a permanent address, and recommends that the agency review its rules and regulations and policy and procedures to identify and remove any other impediment to the expeditious provision of services to the homeless that might exist. Where applicable, the Department is urged to expedite service applications of the chronically mentally ill as they are discharged from state hospitals.

Beyond providing temporary assistance to transients, however, the Committee is persuaded that no central plan exists for assisting the homeless in becoming permanently placed. The Section 8 experimental housing program run by Social and Rehabilitation Services in cooperation with the Department of Housing and Urban Development seems to represent a step in the direction of permanence and is applauded by the Committee. Further, Social and Rehabilitation Services should

be supported in its efforts to attract additional funds to the program and should be directed to extend the housing assistance programs to other geographical areas of need in the state as funds are available.

The Committee has been made aware that the lack of housing and the shortage of affordable housing are only two elements which create or contribute to homelessness. Clearly, among other conditions, the homeless are frequently uneducated or under-educated for contemporary life; the homeless lack skills to compete for existing jobs; and the homeless possess identity problems which inhibit their taking advantage of the limited opportunities afforded them. For these conditions, the Committee found no extant remedies. Additionally, the Committee could find no way precisely to distinguish the homeless and their needs identified under Proposal No. 27 from many of the persons and needs identified in Committee study of access to health care for the medically indigent under Proposal No. 24. (See the Committee Reports on Proposal No. 24 in this volume.)

Finally, having to some extent identified who the homeless are in Kansas and what conditions give rise to and perpetuate the homeless state, and after discovering the interrelatedness of the topics assigned for study, the Committee recommends that the 1987 Legislature create a commission to follow up the work of the Special Committee on Public Health and Welfare as it pertained especially to Proposal Nos. 24 and 27. The Commission should build upon, not recreate the work and findings of this interim special committee, and should make recommendations to subsequent legislatures that will contribute to the creation of programs and opportunities leading to permanent placement for the now homeless. (For more details on the membership and functions of the proposed commission, see the Committee Report on Proposal No. 24 -- Access to Health Care for the Medically Indigent in this volume.)

Respectfully submitted,

November 24, 1986

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Special Committee on Public Health and Welfare

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Rep. Gary Blumenthal
Rep. Jessie Branson
Rep. Frank Buehler
Rep. Elaine Hassler
Rep. Melvin Neufeld

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Sen. Jack Walker